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Montana
Chronic Disease Prevention
& Health Promotion Bureau

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Tracking Diabetes Care

- The Diabetes Quality Care Monitoring System (DQCMS) is a diabetes registry software program available at no cost to health care providers.
- It allows providers to track diabetes care in the outpatient setting and improve care based on the indicators tracked.
- DQCMS is not an electronic medical record, nor does it monitor care for other chronic diseases besides diabetes.
- Non-DQCMS users can still benefit from submitting their clinical data from their medical records to the Montana Diabetes Program using an Excel reporting sheet.
- Both DQCMS and non-DQCMS users receive quarterly graph reports and annual trend reports showing their data compared to state averages and goals.

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Tracking Quality Measures

- DQCMS can track NQF indicators 0059 for A1C > 9% and NQF 0018 for Blood Pressure < 140/90 mmHg
- Non-DQCMS users can report their data on these indicators utilizing the Excel reporting sheet.
- Quarterly reports will show how the health care provider and health care system as a whole is doing each quarter and a 3-year trend report is prepared at the end of the year to show long-term trends.

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Improving Diabetes Care

DQCMS

Diabetes *Quality* Care Monitoring System

- Quality improvement projects and support are available to assist health care providers and health care systems improve their care and quality measures.
  - ABC (A1C, Blood Pressure, and Cholesterol) letters are generated by DQCMS
  - A1C control projects aimed at reducing the proportion of patients with diabetes with A1C >9%
  - Blood pressure control projects aimed at increasing the proportion of patients with blood pressure <140/90 mmHg
  - Medication adherence projects

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DPP Overview

- **Goals**
  - 5% to 7% weight loss
  - Improved nutrition and increased physical activity (>150 min/week)
- **Facilitation**
  - Delivered by trained lifestyle coaches (health care professional such as an RD, RN, CDE, PT, or exercise physiologist)
- **Curriculum**
  - Group-based education
  - CDC National DPP curriculum, based upon the NIH Lifestyle Balance curriculum
  - 1 year program with 16 core classes followed by 6 post core classes
  - Healthy eating, physical activity, and problem solving content
  - Self-monitoring food and physical activity

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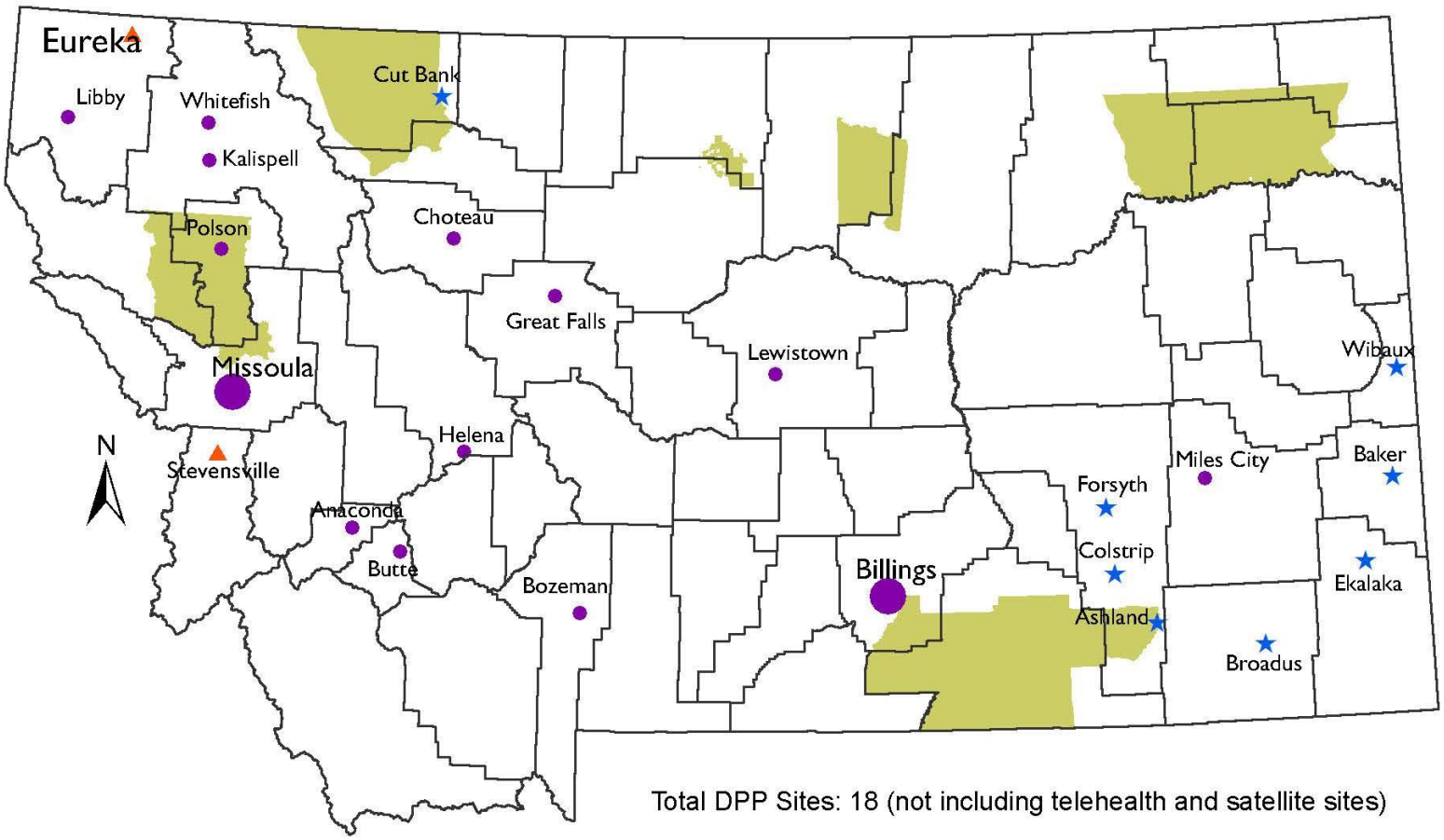
Figure 1. Montana Diabetes Prevention Program Sites, 2015



Sites, Number ( )

- Satellite (2)
- Telehealth (8)
- 1 Site
- 3 Sites
- American Indian Reservations

Montana Cardiovascular Disease & Diabetes Prevention Program
Chronic Disease Prevention & Health Promotion Bureau

Data Source: Montana Diabetes Program
Created by: Montana Diabetes Program, 1/2/2015

Table. Characteristics and outcomes at 4 months among participants in the Montana Diabetes Prevention Program, 2008-2012.

	All participants, 2008-2012 (n=3,804)
	Mean (SD)
Age (years)	53 (12)
Baseline BMI (kg/m^2)	36 (7)
Number of core sessions attended	14 (4)
Weight loss (kg)	5 (6)
	% n
Sex (female)	82 (3,109)
Self-monitoring fat intake ≥7 weeks	66 (2,289)
Achieved 150 min physical activity per week	64 (2,072)
Achieved 7% weight loss	34 (1,300)

Data Source: Diabetes Prevention Program, Montana, 2008-2012.

Contact Information

DQCMS
Diabetes *Quality* Care Monitoring System

For more information on diabetes quality improvement projects, use of EHRs and a registry for tracking diabetes care, and how to become a participating practice with the Montana Diabetes Project please contact:

Chris Jacoby, RN, BSN
Quality Improvement Coordinator
cjacoby@mt.gov

www.diabetes.mt.gov

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PCMH Blood Pressure (BP) Project

- Goal:
  - Optimize use of electronic health record to help identify patients with undiagnosed hypertension (HTN)
    - Criteria – 2+ BP readings >140/90 in the past year without HTN diagnosis
- Requirements:
  - Conduct outreach & initiate treatment, if needed
  - Collect National Quality Forum (NQF) 0018 measure (BP control)
- Eligibility: Qualified PCMH

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Primary Care Facility (PCF) BP/Diabetes Project

- Goal: Implement clinical systems/policies to enhance management of patients with hypertension and/or diabetes
- Requirements:
  - Multidisciplinary team-based care
  - Promote self-measured BP monitoring
  - Report NQF 0018 (bp)/NQF 0059 (diabetes control)
  - BP quality improvement
- Eligibility: PCF (non-CHC) or Rural Health Clinic

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Funding Opportunities

- Next PCMH and PCF sub-awards announced Fall 2015
  - $5,000 each
  - Technical assistance available from Cardiovascular Health Program and Regional Extension Center (REC)
  - Contact Crystelle Fogle, cfogle@mt.gov

Primary Care Facility Hypertension and Diabetes Project

Million Hearts Workgroup
Marilyn McLaury, MS, RD

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Primary Care Project Intent

Use EHR to collect National Quality Forum (NQF) measures
-NQF 0018 Controlling high blood pressure
-NQF 0059 Diabetes care (poor control A1C > 9.0)

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Implement clinical systems and/or policies to enhance management of hypertension and diabetes focusing on:

- Multidisciplinary team-based care

- Promotion of self-measured blood pressure monitoring

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Participating Sites

- Community Physicians Group
- Frontier Family Practice
- Glacier Medical Associates
- Great Falls Clinic
- St. Luke Community Healthcare
- St. Peter's Medical Group
- St. Vincent Physician Network

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Summary

- Sites established self-management programs
- Hypertension protocols were adopted
- Multi-disciplinary team care is being used by all sites

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Benefis Medical Group

- Joined the Measure UP/Pressure Down blood pressure campaign
- Implemented a policy requiring collection of vital signs at each visit with BP entry mandatory
- Used automated vital sign monitors to download the BP measurement directly into the EHR

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Benefis Medical Group

- Developed a hypertension registry to identify patients with hypertension and those lost to follow-up
- Established monthly provider and system-level feedback reports
- Initiated the patient portal

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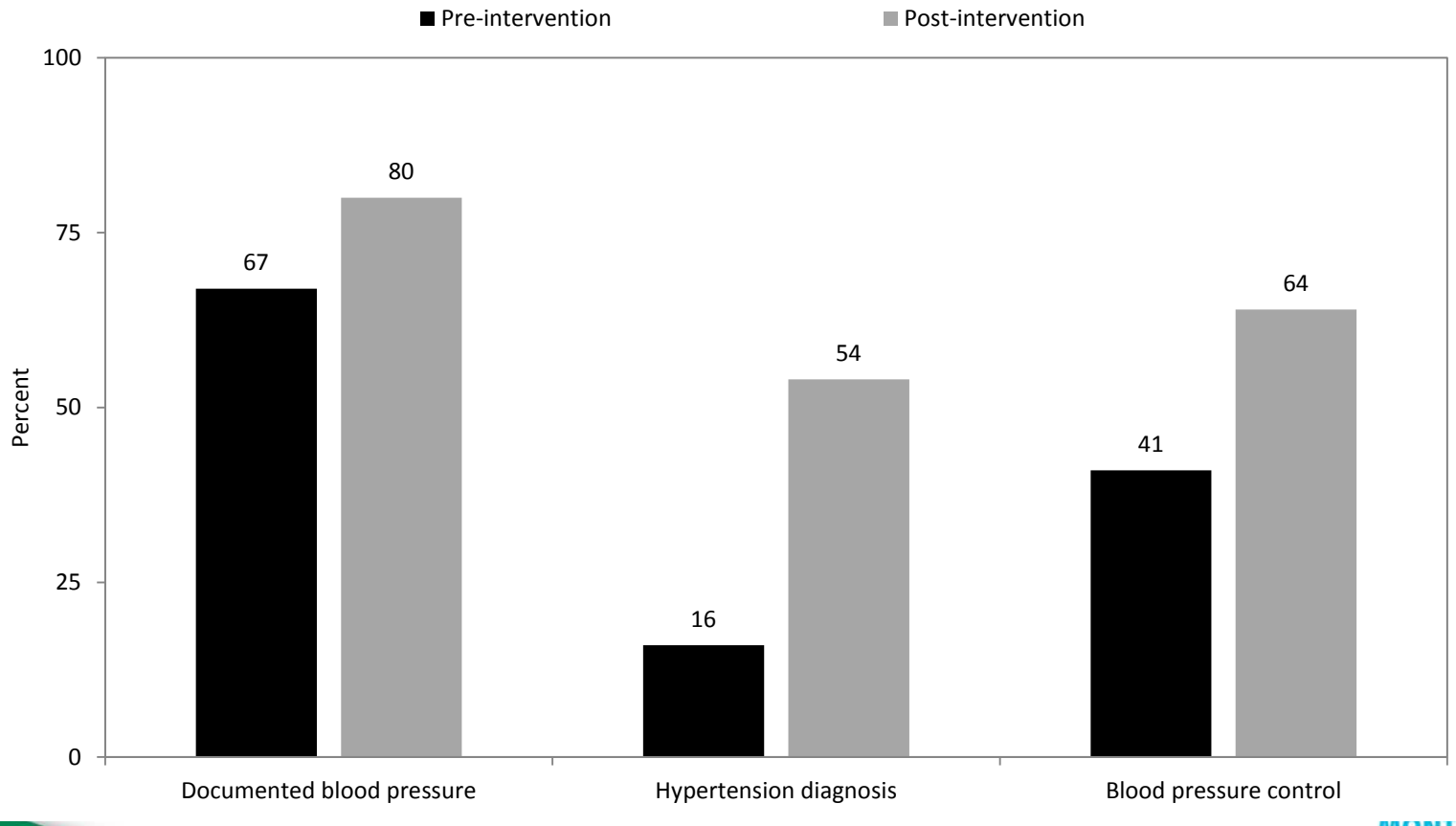
Adult patients screened for hypertension, diagnosed for hypertension and blood pressure control rates among adult patients seen at Benefis Medical Group, Great Falls, Montana, 2012-2013.



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Montana Tobacco Quit Line: Electronic Referral Project

- An electronic referral system would allow hospitals to refer patients directly to the quit line using their existing Electronic Health Records (EHR).
- This system would:
  - Allow two way communications with the EHR.
  - Would replace our fax referral system and allow a quicker and easier way for doctors to refer their patients to the quit line.
- Interested pilot sites include:
  - St. Vincent, St. James and Holy Rosary
  - Kalispell Regional
  - Riverstone Health
  - Livingston HealthCare

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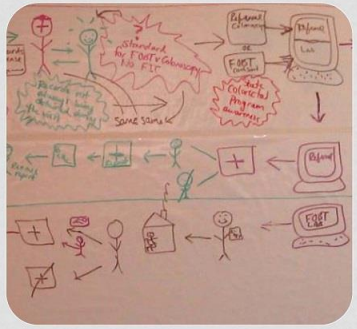
Increasing colorectal cancer screening among patients at six Federally Qualified Health Centers in Montana

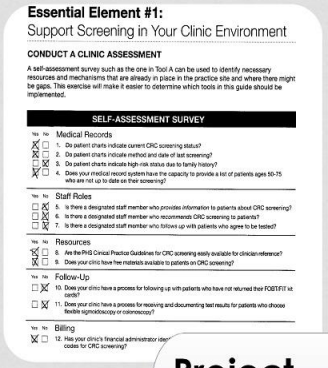
a pilot project

Leah R. Merchant and Laura L. Williamson, MPH

A3/LEAN Process



Clinic Self-Assessment



Essential Element #1:
Support Screening in Your Clinic Environment

CONDUCT A CLINIC ASSESSMENT

A self-assessment survey such as the one in Tool A can be used to identify necessary resources and mechanisms that are already in place in the practice site and where there might be gaps. This exercise will make it easier to determine which tools in this guide should be implemented.

SELF-ASSESSMENT SURVEY

Yes	No	
		Medical Records
X		1. Do patient charts indicate current CRC screening status?
X		2. Do patient charts indicate method and date of last screening?
	X	3. Do patient charts indicate high-risk status due to family history?
X		4. Does your medical record system have the capacity to provide a list of patients ages 50-75 who are not up to date on their screening?
		Staff Roles
	X	5. Is there a designated staff member who provides information to patients about CRC screening?
	X	6. Is there a designated staff member who recommends CRC screening to patients?
	X	7. Is there a designated staff member who follows up with patients who agree to be tested?
		Resources
X		8. Are the PHG Clinical Practice Guidelines for CRC screening easily available for clinician reference?
X		9. Does your clinic have free materials available to patients on CRC screening?
		Follow-Up
	X	10. Does your clinic have a process for following up with patients who have not returned their FOBT/FIT kit cards?
	X	11. Does your clinic have a process for receiving and documenting test results for patients who choose flexible sigmoidoscopy or colonoscopy?
		Billing
X		12. Has your clinic's financial administrator identified codes for CRC screening?

Results of Clinic Self-Assessment

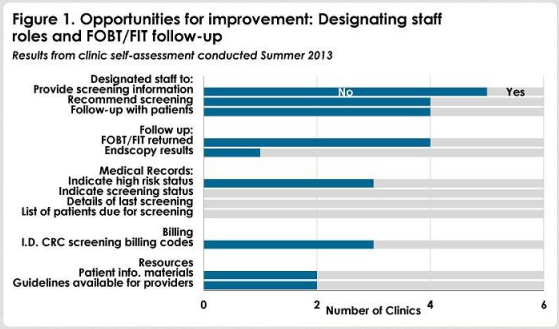


Figure 1. Opportunities for improvement: Designating staff roles and FOBT/FIT follow-up

Results from clinic self-assessment conducted Summer 2013

CRC Screening Status

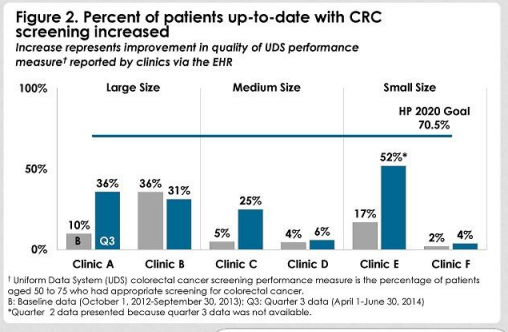


Figure 2. Percent of patients up-to-date with CRC screening increased

Increase represents improvement in quality of UDS performance measure† reported by clinics via the EHR

† Uniform Data System (UDS) colorectal cancer screening performance measure is the percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer.
B: Baseline data (October 1, 2012-September 30, 2013); Q3: Quarter 3 data (April 1-June 30, 2014)
*Quarter 2 data presented because quarter 3 data was not available.

Background

Issue

- Colorectal cancer (CRC) is the third most common type of cancer among men and women in Montana. CRC mortality can be significantly reduced through universal CRC screening.
- In 2012, 56% of Montana adults were up-to-date with CRC screening—ranking Montana the third lowest among U.S. states with regard to the percent of adults up-to-date with CRC screening.

Setting

- The Health Resources and Services Administration (HRSA) requires all Federally Qualified Health Centers (FQHC) to annually report on a core set of performance indicators called the Uniform Data System (UDS). CRC screening is a UDS measure.
- The setting of this project took place in six FQHCs throughout Montana. The clinics were of various sizes: large (> 1,000 patients), medium (300 to 1,000 patients), and small (< 300 patients).

Special acknowledgement and thanks to the Montana Primary Care Association, Paula Block, RN, BSN, Marge Levine, MS, RD, and the staff of the six participating Montana Community Health Centers.

Project

- The Montana Cancer Control Programs and the Montana Primary Care Association partnered to provide technical assistance and funding to six FQHCs to establish office systems to increase CRC screening among clinic patients according to United States Preventive Services Task Force clinical guidelines.
- The project period is 12-months (October 1, 2013 – September 30, 2014). Results at the end of quarter 3 (June 30, 2014) are presented.
- Strategies used followed The Guide to Community Preventive Services and the University of North Carolina's 2011 Toolbox for Community Health Centers (referred to as "The Toolbox"), which was adapted from the "*How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide*".
- FQHCs participated in a facilitated A3/LEAN to identify opportunities for improvement in their clinic environment to increase CRC screening. Monthly technical assistance conference calls were also conducted.
- Each FQHC was required to quarterly report on four evaluation measures using the clinic's electronic health record: (1) CRC screening tests ordered , (2) tests completed, (3) the type of test completed, and (4) the percent of patients up-to-date with CRC screening (UDS measure).

Results

Self-Assessment

- The Toolbox clinic self-assessment revealed that the majority of the clinics (4 of 6) identified that designating staff to CRC screening activities was needed (Figure 1).
- Four clinics identified that a process was needed to follow-up on unreturned FOBT/FIT kits (Figure 1).

Outcome measures

- Six clinics identified gaps in EHR data mapping and identified EHR repairs needed to improve the quality of the CRC screening UDS measure.
- At the end of quarter 2 it was determined that clinics were either unable to accurately capture outcome measures in their EHR (measure 1) or that the measure was not useful because it did not inform their clinic environment (measures 2 and 3). It was decided to no longer collect data on measures 1 through 3.
- Five of six FQHCs increased the reported percent of patients up-to-date with CRC screening from baseline to quarter 3 (UDS measure) (Figure 2).
- Because several challenges were identified with the EHR reporting CRC screening status, the documented increase in CRC screening is primarily attributed to improved data quality rather than a true increase in the number of patients screened.

Conclusions

Lessons Learned

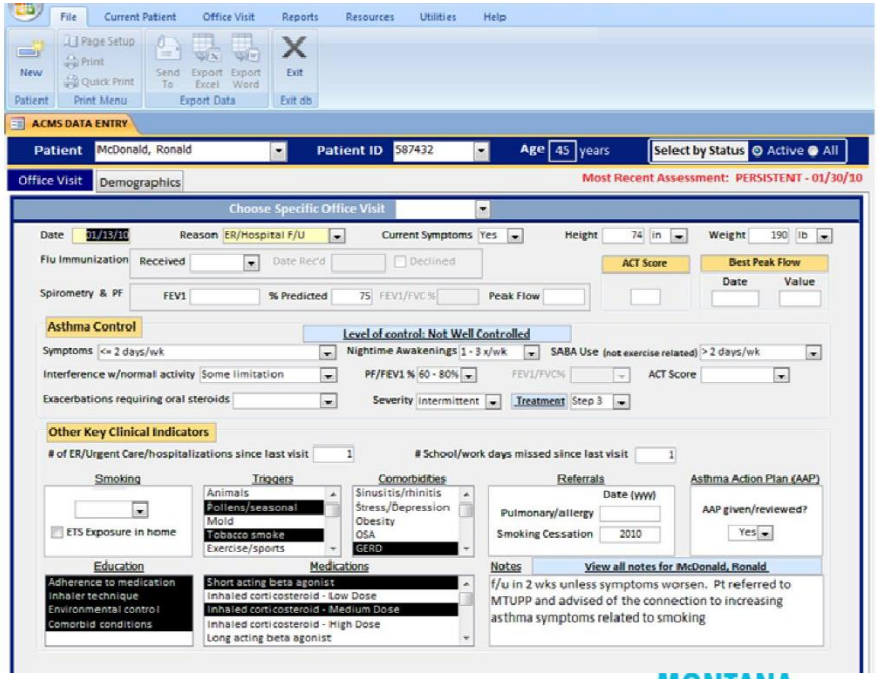
- Outcome evaluation measures should follow measurements that FQHCs must already report (*e.g.*, UDS). Other measurements may create too much added work and may not be informative to the clinic.
- Up-front work is needed to improve data quality before being able to effectively focus on increasing CRC screening rates.
- Office capacity, FQHC staff time, and clinic project readiness are considerations before establishing partnerships.

Recommendations

- It is recommended that this project continue for an additional 12 months so that clinics may further refine office systems and collect quality data from the EHR to sustain regular CRC screening among patients. Office systems established for this project to increase CRC screening may be applicable to other preventive services at FQHCs.
- By sharing best practices with clinics, public health can assist FQHCs to improve quality of measures that clinics are required to report (*e.g.* UDS, Patient Centered Medical Home, or Meaningful Use).

Asthma Care Monitoring System (ACMS)

- Stand alone software
- Records asthma symptoms, medications, and education provided at each office visit
- Contains features to help with recalling and reminding patients
- Creates quarterly report to measure several quality measures, including UDS



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Questions

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